ANNUAL TRAINING - RESERVE COMPONENT

Please mail packets with original signatures on ICTB and forms:

ICTB signed by your Commander
copies of licenses and BCLS
civilian hospital privileges
Request for Clinical Privileges memorandum
DA Form 5753 USAR *APPLICATION FOR PRIVILEGES* (the Reverse is signed by your Credentials and Commander, Section D will be signed by RACH credentials and Commander)
DA Form *5440A DELINEATION OF PRIVILEGES RECORD* completed by the HCP (section 3 and 4 will be signed RACH chiefs and Cdr)
DA Form 5440-series *DELINEATION OF PRIVILEGES - SPECIALTY* initialed by HCP (will be initialed/approved by RACH chief)
DA 5754 *MALPRACTICE AND PRIVILEGES QUESTIONNAIRE*
RACH *RELEASE OF INFORMATION*

We need the dates that the HCPs will be doing the AT and where they will be. (Fort Sill, Fort Chaffee....) We need to know if they will be working strictly in the field doing level III sick call or if the HCPs will practice or order labs/prescriptions at the TMC.

If the HCPs are doing ONLY sick call in the field, and are not going to access the TMC we only need the ICTB, licenses, CPR and civilian privileges.

Debra Flores
Credentials Coordinator
Reynolds Army Community Hospital
Fort Sill, OK 73503-6300
(580) 458-2647 fax (580) 458-2314
DSN 866-2647

Date:_____

MEMORANDUM THRU, Chief, Dept of _____

FOR Chairperson, Credentials Committee, Reynolds Army Community Hospital, Fort Sill, OK 73503

SUBJECT: Request for Clinical Privileges and Medical Staff Appointment (If Applicable)

1. I request clinical privileges and an appointment to the medical staff, if applicable, at Reynolds Army Community Hospital as specified on the enclosed DA Form 5440 Series, Delineation of Privileges form.

2. I certify that I possess the necessary skills and expertise to justify granting of clinical privileges in those areas I have indicated on the forms, and that I am clinically competent to perform in those areas.

3. If any change in my mental or physical state occurs during a privileging period, I will immediately, or as soon as I am physically able, notify a designated supervisor.

4. I certify that I am currently in good health, that I am able to perform the privileges requested, with or without reasonable accommodation, and that I do not have any physical or mental conditions which would preclude or affect my performance in providing the requested health care services. I do not have and have not had any significant illness(es) including psychiatric and alcohol/drug abuse, nor have I had any major surgical procedures that would impact, prevent or preclude my performance, except as listed below:

_____

_____

_____
Signature Date

_____
Please print name

Ist Ind: Physician Supervisor

To the best of my knowledge, the above information stated in question #4 is correct.

_____
Physician Supervisor's signature Date

_____
Physician Supervisor's printed name

USAR OR ARNG APPLICATION FOR CLINICAL PRIVILEGES TO PERFORM ACTIVE OR INACTIVE DUTY TRAINING

For use of this form, see AR 40-68; the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title, 5, United States Code (USC), Sections 301; Title 44, USC, Section 3101; and Title 10, USC, Section 1071.

Principal Purpose: To define the extent and limits of the practitioner's clinical privileges as a function of his or her training experience.

Routine Uses: Determine and asses capability of practitioner's clinical practice. A copy of this form will be retained in your credentials file. Information may be provided to certain civilian hopitals, the Federation of State Medical Boards of the U.S., State Licensure authorities, and other appropriate professional regulating bodies.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may result in the limitation or termination of your clinical privileges.

SECTION A - IDENTIFICATION

1. NAME *(Last, first, middle)*	2. SOCIAL SECURITY NO. *(SSN)*	3. DOB	4. GRADE

5. CORPS	6. UNIT IDENTIFICATION	7. SPECIALTY BY TRAINING

SECTION B - BASIC INFORMATION

8. LICENSURE/CERT.	9. DATE(S)	10. EXPIRATION DATE(S)
a. State Licensure *(If any)*		
b. DEA Number *(If any)*		
c. CPR Certificate		
d. ACLS Certificate		
e. BCLS Certificate		

11. BOARD ELIGIBLE FROM *(Date)*	12a. BOARD EXAM TAKEN *(Date)*	12b. CHECK ☐ Total ☐ Partial	14. MEMBERSHIP IN SPECIALTY SOCIETIES *(Specify)*

13. BOARD CERTIFIED? *(If yes, give name of Board(s).*
☐ Yes ☐ No

15. Current Hospital Privileges

a. NAME OF HOSPITAL	b. LOCATION	c. TYPE OF APPOINTMENT

16. Interval information *(If Yes to any of the following questions, give full details on a seperate sheet of paper.)*

In the last year, have you:	YES	NO
a. Have you had any final unfavorable liability judgments?		
b. If yes, any liability payments above $100,000?		
c. Have you been the subject of **any** disciplinary action by **any** local or state medical society or **any** licensing agency?		
d. Have you had you clinical privileges limited, revooked, or otherwise modified at **any** institution?		
e. Resigned from the staff of any hospital?		
f. Been treated for drug or alcohol abuse?		
g. Not maintained you state's continuing medical education requirements?		

	YES	NO
h. Would you feel comfortable and competent to perform your AD Training as a General Medical Officer in the **Outpatient Clinic?**		
i. Would you feel comfortable and competent to perform your AD Training as a General Medical Officer in the **Emergency Care area?**		
j. Do you certify that you are mentally and physically able to practice medicine?		

17. COMMENTS

The information contained herein is true to the best of my knowledge and belief.	18a. SIGNATURE OF APPLICANT	18b. DATE

SECTION C - ARNG OR USAR UNIT COMMANDER'S RECOMMENDATIONS

That clinical privileges be granted to the named applicant for Active or Inactive duty.

1 NAME

2 PERIOD

FROM | TO

3 MEDICAL TREATMENT FACILITY OR DENTAC

4 BY EDUCATION AND TRAINING, THIS PRACTITIONER IS QUALIFIED IN THE FOLLOWING

5 PRACTITIONER'S DEMONSTRATED CLINICAL COMPETENCY REMARKS

SPECIALTIES	UNKNOWN	YES	NO
a Primary →			
b Secondary →			
6 This practitioner has the capability of performing the medical duties required of a General Medical Officer or General Dentist			
7 All documents of education, training, licensure/certification/registration and ECFMG (if applicable) have been verified with a primary source			

8a NAME OF VERIFYING INDIVIDUAL | 8b GRADE | 8e SIGNATURE

8c TITLE | 8d DATE

9a NAME OF UNIT COMMANDER | 9b GRADE | 9e SIGNATURE

9c TITLE | 9d DATE

SECTION D - RECOMMENDATIONS OF SITE CREDENTIALS COMMITTEE

10 REMARKS

11 RECOMMENDED STATUS

☐ Conditional ☐ Full

12 CLINICAL PRIVILEGES RECOMMENDED

☐ As Requested ☐ Other *(Specify in Item 12)*

13a NAME OF CREDENTIALS COMMITTEE CHAIR | 13b GRADE

13c SIGNATURE | 13d DATE

SECTION E - APPROVING AUTHORITY

14a NAME OF MTF OR DENTAC COMMANDER | 14b SIGNATURE | 14c DATE

INITIAL appropriate Category

Sections 1, 3, 4 & 5-leave BLANK

Section 6-COMPLETE

DELINEATION OF PRIVILEGES RECORD

For use of this form, see AR 40-68; the proponent agency is OTSG

1. PERIOD FROM TO

2. the Appropriate Category

	A. Anesthesia		I. Pediatrics		Q. Nurse Practitioners *(Adult)*
	B. Dentistry		J. Podiatry		R. Nurse Practitioners *(Pediatric)*
	C. Family Practice		K. Psychiatry		S. OB/GYN Nurse Practitioners
	D. Internal Medicine &		L. Psychology		T. Physician Assistants
	E. Neurology		M. Radiology/Nuclear Medicine		U. Emergency Medicine
	F. Obstetrics & Gynecology		N. Surgery		V. Other Specialty *(Specify)*
	G. Optometry Service		O. Nurse Anesthetists		
	H. Pathology		P. Nurse Midwives		

3. Recommendations

A. MEDICAL TREATMENT FACILITY/DENTAC
Reynolds Army Community Hospital
Fort Sill, Oklahoma 73503-6300

B. STATUS
- ☐ (1) Temporary
- ☐ (2) Provisional
- ☐ (3) Courtesy
- ☐ (4) Consulting
- ☐ (5) Full *(Appointment Status)*

C. CLINICAL PRIVILEGES
- ☐ (1) Granted as Requested
- ☐ (2) Modified as Recommended
- ☐ (3) Other *(See Remarks)*

D. DEPT./SVC *(Specify)*

E. DATE

G. CREDENTIALS COMMITTEE
WILLIAM B. DAVIS, LTC, MC
CHAIRPERSON

H. DATE

F. SIGNATURE

I. SIGNATURE

4. Approval

A. NAME OF HOSPITAL/DENTAC COMMANDER
KARL R. KERCHIEF, COL, MC Commanding

B. SIGNATURE

C. DATE

5. Remarks

APPOINTMENT

___Initial
___Active
___Affiliate
___No Appointment

PRIVILEGES

___Regular
___Temporary
___Supervised

This provider (IS) (IS NOT) granted admitting privileges to RACH

Based upon my knowledge, I attest to the validity of this practitioner's personal description of his or her physical and mental status.

6. Practitioner's Education/Training Update

A. BOARD ELIGIBLE FROM *(Date)*

B. BOARD EXAMINATION TAKEN *(Date)*
☐ Total ☐ Partial

C. BOARD CERTIFIED
☐ No ☐ Yes *(Give Name of Board)*

D. RECERTIFICATION *(Board and Date)*

E. UTILIZED IN PRIMARY SPECIALTY
Yes/No

F. YEARS AND DATES OF SPECIALTY TRAINING *(Specify only training since initial application)*

G. TOTAL HOURS OF CONTINUING EDUCATION THIS PERIOD

H. TOTAL HOURS OF SUB-SPECIALTY BOARD THIS PERIOD *(Specify)*

J. NAME OF APPLICANT OR PRACTITIONER

I. MEMBERSHIP IN SPECIALTY SOCIETY(IES) *(Specify)*

K. SIGNATURE

L. DATE

MALPRACTICE AND PRIVILEGES QUESTIONNAIRE

For use of this form, see AR 40-68; the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority:: Title 5, United States Code (USC), Sections 3109 and 3301. *(Title 5, USC, Section 552a)*

Principal Purpose: To obtain U.S. Civil Service appointment.

Routine Uses: Basis for determination of qualifications and background information for the eligibility for appointment. Basis for credentialing health care providers.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information will result in nonacceptability of the application.

The policy of the Army is to screen, verify and validate statements, assertions and documents of all applicants for health care provider positions. As part of this process, please complete the following statements *(as applicable to your profession)*.

1 NAME OF INDIVIDUAL	2. SOCIAL SECURITY NO. *(SSN)*

Please use your INITIALS to answer questions 3 thru 12

HAVE *(YES)*	HAVE NOT *(NO)*		
		3.	Had medical liability claims, settlements, judicial or administrative adjudications, or any other resolved or open charges of inappropriate, unethical, unprofessional or substandard professional practice. *(If affirmative explain each incident in item 13 below.)*
		4.	I am licensed/registered/certified by the authority named in item 13 below. *(List all current and past licensures held (include issue and expiration date). Explain the circumstances surrounding the suspension or revocation of licensure previously held.)*
		5.	Had my professional license denied, withdrawn, or restricted by a state or local licensing board or other authority. *(If affirmative, give the organization name, address, and dates involved in item 13 below.)* voluntarily/involuntarily
		6.	Had professional privileges denied, withdrawn, or restricted by a health care facility. *(If affirmative, give the organization name, address, and dates involved in item 13 below.)* voluntarily/involuntarily
		7.	Resigned or otherwise disassociated myself from employment or practice after being notified of intent to start action against me for failure to properly accomplish my professional responsibilities. *(If affirmative, give the organization name, address and dates involved in item 13 below.)*
		8.	Are you now or have you ever been required to appear before any medical or state regulating authority, regardless of the result, concerning your status as an impaired, hindered, or otherwise restricted practitioner? *(If affirmative, give brief explanation in item 13 below.)*
		9.	Had a history of drug or alcohol abuse or misuse. *(If affirmative, explain in item 13 below.)*
		10.	Do you have any disease or impairment which would make your employment a hazard to yourself or others? *(If affirmative, please list in item 13 below. In addition, please provide a brief description of your health status.)*
		11.	I hereby authorize the U.S. Army to contact my current and previous malpractice carrier/licensing organizations for the purpose of verifying the above information.
		11a	CARRIERS *(Name and Address, current and previous)*
		11b.	POLICY NO
		11c.	LICENSING ORGANIZATIONS *(Name and Address, current and previous)*
		12.	I hereby authorize the U.S. Army to contact the following institution(s) for the purpose of verifying the status of my current professional privileges:
		12a.	ORGANIZATION *(Name and Address)*
		12b.	DATE(S)

13. CLARIFICATIONS, EXPLANATIONS ETC. REGARDING ITEMS 3-10 ABOVE *(Identify by appropriate item number.)* (Continue on reverse side if necessary.)

HOME ADDRESS		HOME TELEPHONE #
14a. TYPED/PRINTED NAME OF APPLICANT	14b. SIGNATURE OF APPLICANT	14c. DATE

STATEMENT OF AFFIRMATION/RELEASE OF INFORMATION

I FULLY UNDERSTAND THAT ANY SIGNIFICANT MISSTATEMENTS IN OR OMISSIONS FROM THIS APPLICATION CONSTITUTE CAUSE FOR DENIAL OF APPOINTMENT OR CAUSE FOR WITHDRAWAL OF STAFF PRIVILEGES. ALL INFORMATION SUBMITTED BY ME ON THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

By applying for appointment/reappointment to the medical staff of Reynolds Army Community Hospital I make this ethical pledge that I will provide continuous care to my patients and will refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a medical or dental practitioner who is not qualified to undertake this responsibility and who is not adequately supervised. I will seek consultation whenever necessary, will refrain from providing "Ghost" surgical and/or medical services, and will refrain from fee splitting or other inducements to patient referral.

I will not conduct or assist in the practice of medicine at any other institution unless specific approval is granted in writing by the Commander in accordance wih applicable regulations (active duty only).

I have read and agree to abide by the rules, regulations, and By-laws of Reynolds Army Community Hospital as currently written or hereafter amended, pertaining to medical practice. Moreover, I specifically pledge that I will not accept any compensation from patients, insurance companies or other sources for services rendered at Reynolds Army Community Hospital. I pledge not to receive compensation from beneficiaries entitled to care by regulation regardless of where care and/or treatment is performed, nor will I accept compensation directly or indirectly from the federal government through outside employment. Should I receive such payment, I will release it to the Treasurer of the United States.

By applying for appointment/reappointment to the medical staff, I hereby signify my willingness to appear for interviews necessary in regard to my application. I hereby authorize the Commander, Credentials Committee, or their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character, ethical and educational qualifications. I hereby further consent to release from any liability all individuals and organizations who provide information to Reynolds Army Community Hospital or its medical staff, in good faith and without malice, concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information by said individuals and organizations, to include any adverse information deemed appropriate, to Reynolds Army Community Hospital. A copy of this statement shall be as binding as the original.

_____ _____

DATE SIGNATURE

_____

PRINT FULL NAME AND RANK

_____

DATE OF BIRTH/SOCIAL SECURITY NUMBER

January 29, 1999

MEMORANDUM FOR SECRETARY OF THE ARMY
SECRETARY OF THE NAVY
SECRETARY OF THE AIR FORCE

SUBJECT: DoD Policy on Physician Licensure

Since 1988, under 10 USC 1094 (and currently DoD Directive 6025.13, "Clinical Quality Management Program in the Military Health Services System," July 20, 1995), the Department of Defense (DoD) has required all physicians to have a medical license to practice. However, some States have permitted military physicians to be licensed in special licensure categories that waive certain requirements (such as standard license fees) and include restrictions on the scope of practice (such as limited to federal facilities). Section 1094 was amended by section 734 of the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999, Pub. L. 104-261. The amendment takes effect October 1, 1999. The law now provides (with the amendment shown in italics):

> (a)(1) A person under the jurisdiction of the Secretary of a military department may not provide health care independently as a health care professional under this chapter unless the person has a current license to provide such care. *In the case of a physician, the physician may not provide health care as a physician under this chapter unless the current license is an unrestricted license that is not subject to limitation on the scope of practice ordinarily granted to other physicians for a similar specialty by a jurisdiction that granted the license.*
>
> (2) The Secretary of Defense may waive paragraph (1) with respect to any person in unusual circumstances. The Secretary shall prescribe by regulation the circumstances under which such a waiver may be granted.

In implementing this law, DoD policy is guided by a commitment to achieve, and assure the public that we achieve, an unsurpassed standard of quality medical care. Implementation shall adhere to the following policies:

1. Unrestricted license. Any physician license in a licensure category that restricts the physician to practice in a federal facility or within some other confined limits does not comply with the requirement for an "unrestricted license." Unless waived, all physicians must have at least one current, unrestricted license. Physicians may hold additional licenses from States in licensure categories that have practice restrictions associated with military exemptions from certain fees or other requirements as long as the physician also holds at least one license for which there are no limitations on the scope of practice. Effective October 1, 1999, a physician without a full-scope license may not provide health care as a physician, unless a waiver is granted under this policy.

2. No waiver of clinical competency standards. A licensure category that includes limitations on scope of practice shall not be considered for a waiver of the unrestricted license requirement unless it includes all the same requirements pertaining to clinical competency (e.g., education, training, tests, continuing medical education, investigation and sanction authority of the licensure board) as the full scope category and has no restrictions pertaining to clinical competency (e.g., practice under supervision). A waiver shall be considered only if the differences between the full scope license and limited scope license are solely of an administrative or financial nature.

3. Waiver possible for administrative or financial requirement inharmonious with federal policy. The statute permits a waiver of the unrestricted scope requirement only in "unusual circumstances." A requirement to pay the standard license fee associated with an unrestricted license is not an unusual circumstance and is not a basis for use of the waiver authority. A waiver may be considered in cases in which the administrative or financial requirements applicable to the full scope license that are not applicable to the limited scope license are substantial and seek to achieve a State purpose clearly inapplicable to military physicians based on federal policy. Examples of this would be a requirement that the physician reside in the State (federal policy calling for world-wide service), pay a substantial amount

into a medical injury compensation fund (federal policy provides for medical injury compensation under federal statutes), or maintain private malpractice liability insurance (federal policy provides for malpractice liability through the U.S. treasury).

4. Careful review process to facilitate implementation consistency. Waiver consideration shall be based on a two-step process. First, the Assistant Secretary of Defense (Health Affairs) shall determine based on a review of a State's licensure requirements that the standards outlined in paragraphs 2 and 3 above are met and identify the particular State administrative or financial requirements that may be considered for waiver. Requests for this determination may be made by a Surgeon General. The Risk Management Committee shall consider such requests and make recommendations to the ASD(HA). Step two of the process shall be that individual physicians who do not hold a full scope license in any State but who hold a limited scope license in a State for which a waiver may be considered based on the step one determination may request a waiver from the Surgeon General of the Service involved. The request must include a justification for the waiver in the case of the individual physician. A waiver would not be granted for longer than the applicable time period of licensure; a subsequent licensure renewal would require a new waiver. The Surgeons General shall submit to the ASD(HA) an annual account of the waivers granted and the applicable justifications.

My point of contact for questions is Captain Peg Orcutt who may be reached at (703) 681-1703 or by e-mail: Margaret.Orcutt@ha.osd.mil.

////SIGNED\\\\
Dr. Sue Bailey

HA POLICY 9900007

My signature below indicates acknowledgement and compliance with the licensure policy.

Printed Name (Last, First, MI)	(Rank/Status)	(Signature	(Date)
Printed Name (Last, First, MI)	(Rank/Status)	(Signature	(Date)
Printed Name (Last, First, MI)	(Rank/Status)	(Signature	(Date)
Printed Name (Last, First, MI)	(Rank/Status)	(Signature	(Date)
Printed Name (Last, First, MI)	(Rank/Status)	(Signature	(Date)
Printed Name (Last, First, MI)	(Rank/Status)	(Signature	(Date)
Printed Name (Last, First, MI)	(Rank/Status)	(Signature	(Date)

MTF _____

RMC _____

INSTRUCTIONS: Check ONE of the following 2 paragraphs to identify your request:

A. _____I am applying for a waiver of the following administrative licensure requirement (**CHECK ONE**). I understand that these have already been considered by ASD(HA) and are eligible for waiver if requested. Upon renewal of this license, I must submitted another request for waiver.

_____Florida: Malpractice insurance and Neurological Injury Compensation Association (NICA) = risk pool
_____Kansas: Malpractice insurance and Healthcare Stabilization Fund (risk pool)
_____Massachusetts: Malpractice insurance
_____Oregon: Actual practice within the state
_____Pennsylvania: Malpractice insurance and Medical Professional Liability Catastrophe Loss Fund (CAT Fund) = risk pool
_____Colorado: Malpractice Insurance
_____Any state with mandated residencies or instate patient practice requirements.

_____ documents to Headquarters, US Army Medical Command